IMPORTANT NOTE about the next **General Stakeholders Meeting:**

Our scheduled **March 8 meeting is CANCELED**.

Instead, **WE WILL NEXT MEET on MONDAY, APRIL 5 from 1:30 to 3:00 p.m.**

Accordingly, the scheduled April 12 meeting is also cancelled.

The next Stakeholders Meeting on Monday, April 5th will be at the OVHA Offices in Williston, or you can call in to 866-910-4857, pass code # 489421. Apologies for any inconvenience these changes cause. In the interim, I have provided the Updates below, and I am always happy to speak or exchange email with anyone who has questions about our HIT-HIE planning and program implementation efforts.

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Vermont HIT-HIE Updates A week ago last Friday, I sent out a notice about the funding announcement awards to the State Division of Health Care Reform and to VITL totaling just under $12M of new Federal resources to support HIT and HIE in the state. Based on some of the questions and feedback, it's probably worth reviewing what those just announced funds support and the other Federal resources that will be available to help us expand HIT adoption and implementation. The very short version is that none of that $12M will pay for Electronic Health Records (EHR) at provider practices or hospitals. The EHR investments are from different funding streams.

If you feel confused, it's because it is confusing: we are trying to sort through a myriad of new, still-being-defined Federal programs and initiatives, as well as the State responses to same.

The upside is that when Congress set all of this activity in motion just over a year ago with the passage of ARRA, they appropriated over $40B in new investments in Health Information Technology and Exchange. So it's not surprising that sorting out how that $40B+ gets spent is taking some time and creating some confusion.

In essence, Congress created three funding streams: two through CMS (one each for Medicare and Medicaid) and one through the Office of the National Coordinator (ONC).
- The CMS funds support incentive payments for the adoption and Meaningful Use of EHR systems at physician practices and hospitals.
- The CMS streams have not yet begun to flow to providers (although states, including Vermont, are beginning to receive planning funding for administration of the Medicaid provider incentive payments).
- The ONC streams (which are divided into a number of grant and cooperative agreement programs, like the two mentioned above) have begun to flow, but are several months behind the original dates anticipated for funding awards. Additional ONC funds (such as the Beacon Community grants and workforce funding grants) will be announced in the coming weeks.

The rules for how the CMS funds are dispensed were released for comment (the 500+ page NPRM, or Notice of Proposed Rule Making) on Dec. 30, 2009. Comments are due back on March 15th. (More on Vermont's comments on the NPRM outlined below.) The CMS Rules reflect nearly a year of input through a highly collaborative process with ONC and its HIT Policy and HIT Standards Committees. The Rules propose definitions of Meaningful Use – which providers must demonstrate to qualify for incentive payments – along with other criteria providers must meet, as well as what state Medicaid agencies must do to ensure adequate compliance with the Rules.

Provider Incentives Starting in 201, providers will be able to access Medicare and Medicaid EHR incentive payments IF they meet the (still to be finalized) criteria for Meaningful Use and other criteria (in the case of Medicaid having to do with proportion of Medicaid beneficiaries served). Medicaid provider incentives can potentially begin in late 2010, but I am making *no promises or commitment* about that for Vermont at this stage, until the Rules and our responsibilities under them are finalized.

Remember too that physicians and other individual providers must choose between the Medicare or the Medicaid incentive programs, while hospitals are eligible for a combination of Medicare and Medicaid funding. Except for Critical Access Hospitals (CAH); they will only qualify for the Medicare incentive program. However, physicians at a Rural Health Clinic owned by a CAH should be eligible for Medicaid EHR incentives. (There are some inconsistencies on this point in the NPRM that we expect to be clarified.)

Not to add too much more confusion, but there is an interesting first year opportunity for providers who access Medicaid funding to be eligible for payments when they adopt, implement or upgrade EHR systems. They would need to demonstrate Meaningful Use in subsequent years, but this a recognition by CMS that providers seeing a higher percentage of Medicaid are less likely to have the capital to invest in EHR hardware and software, so the bar for first year incentive payments is lower. Pediatric practices that see a high percentage of children covered under Dr. Dynasaur, for instance, will likely find this an attractive route for financing EHR adoption, implementation, or upgrades.

CMS is funding states at a 90/10 match to complete planning for the Medicaid incentive payment program and establish the administrative infrastructure for the program. Vermont received written formal approval of our request for that planning funding just after the first of the year. We are now in the process of beginning to recruit new "limited service positions" (meaning not permanent state employees but positions which last through the funding period) who will work in the Division of Health Care Reform at OVHA to plan and implement the provider incentive programs. As we move from the planning to the implementation phase, we will also be adding a full time Provider Relations specialist focused on helping Medicaid providers understand the rules for accessing these funds.

At the same time that we're planning implementation of the incentive program, we will be working on a CMS required State Medicaid HIT Plan (SMHP) to outline a broader vision of how the new HIT-HIE infrastructure will be integrated into routine business practices at OVHA.

Vermont continues to lead by example: I am pleased to report that our vision for a comprehensive, integrated approach that goes beyond the Federal focus on physicians and hospitals to include HIT-HIE connectivity for mental health, home health, and long term care providers, as well as public housing and human services agencies and providers, is being very well received by CMS and ONC officials. At a national meeting held in Washington between the recent record breaking snow storms, Vermont was asked to detail our vision and approach, and in every substantive contact with Federal officials, our more expansive vision is again validated and held up as an example for other states.

While this does not necessarily mean we will obtain Federal funding for EHR systems for providers outside Congress' original focus on physicians and hospitals, I am confident that we have an excellent chance of approval for Federal funding of connectivity and exchange (building interfaces between HIT systems at long term care, mental health, and home health agencies and the VITL HIE network).

This will clearly enhance the value and effectiveness of HIT & HIE across the health care continuum and will contribute substantially to both Meaningful Use for physicians and hospitals and toward the more integrated, collaborative system of care envisioned in our broader health care delivery system reforms. My rallying cry on this point is that*fragmentation of care should be a "never event."*

IT-assisted communication across care domains – and integration with public health through bi-directional feeds to Immunization and other registries and other public health reporting and surveillance systems – will enable us to build a health system that can "talk to itself" and facilitate communication for patients, enable them to communicate more effectively with their providers and other professionals engaged in a *system of care*. We have a unique opportunity to bring this vision into operational reality over the next few years in Vermont, building collaboratively on the infrastructure under development with the Blueprint for Health. In fact, the reason we've had to cancel the March 8 Stakeholders Meeting is that I have been invited to present on our vision to the ONC HIT Standards Committee for public systems support to providers' achieving Meaningful Use.

But what about the $12M grants? What are those for? In a word: infrastructure. The $5M Cooperative Agreement provides funding over the next four years to support the detailed implementation planning for, and then the operational expansion of, the statewide HIE network. Funds will be used to hire a full time State HIT Coordinator, as required by ONC, to direct this effort from the state side, and to support the work of VITL as they build out the HIE infrastructure to every hospital service area and every EHR and HIT system statewide. $5M is not actually enough money to do that, so we will be supplementing it with resources from the state HIT Fund, as well as CMS resources that are matched 90/10 to support connectivity to Medicaid providers statewide. In other words, the $5M will enable us to manage and operationalize the vision of system-wide connectivity outlined above.

The $6.7M in ONC funding to VITL to operate a Regional HIT Extension Center (REC) is also for infrastructure, but in this case, it's the infrastructure and operational changes required at physician practices for effective implementation of EHR systems. It's famously said that installing an EHR is an opportunity to replicate electronically all the bad paper-based processes in place at physicians' practices. The notion behind the REC program is, like the agricultural extension center model, to teach best practices and provide technical assistance. It is an excellent fit with VITL's role assisting providers get hooked up to the HIE network and be, in general, the "go to" resource for HIT in Vermont. The grants were intensely competitive and VITL is to be congratulated on its success in obtaining those resources.

A final point to make about the $5M HIE funding is that ONC introduced an interesting wrinkle new in its funding announcements to states:

"The State Health Information Exchange Cooperative Agreement Program is providing funding to states through three separate funding streams.… Category 1: Planning,… Category 2: sub-national/regional (intra-state) HIE,… and Category 3: Nationwide (inter-state) HIE."

We knew about – and wrote our proposal for – categories 1 & 2. Category 3 is a new development and will require some adjustments to both our planning and budget. The Feds have helpfully allocated the budget amounts to the three categories, so the main issue will be sorting out what happens under each category. (For those interested in more granular details, I have attached a PDF entitled "Prgm Guidance CAN Expenditure document" that provides information on what types of expenditures are allowable, by category.)

Finally, Meaningful Use and the NPRM: As noted above, the Proposed Rule for Meaningful Use and other CMS "rules of the road" for their HIT programs are dense and complex. Quite a few organizations will be weighing in with reactions and comment. One area the Division of HCR will be responding to is the definition of hospital-related providers. As written, it would limit physicians and nurse practitioners who should otherwise qualify for the incentive payments if they bill through a hospital. Many, many other states and entities have voiced concern about this, and I believe it will likely be adjusted, so we will add Vermont's voice to that chorus. We will also probably provide feedback suggesting that to achieve the goals of broad EHR adoption, the rules need to ease transition and implementation for small practices. Finally, the NPRM does not offer very specific language with respect to HIE. It treats HIE as a verb, not as a noun, and given the huge Federal investment in state-level HIE infrastructure, there should probably be more explicit requirements for connectivity to state HIE networks, if not in the first stage of Meaningful Use, then in later stages.

The Vermont legislature is also considering legislation that would create state level Meaningful Use requirements tied to participation in the Blueprint for Health and connectivity to VITL. I will be providing feedback and some suggested changes in the language as drafted when House Health Care takes testimony on the bill (H.627) after the Town Meeting week break.

I have attached an *excellent* set of slides put together by Paul Forlenza at VITL on Meaningful Use, for those who want to dig into some of the details without having to actually dive into the full NPRM.

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